



BE PREPARED TO TRANSMIT BY  
ELECTRONIC MAIL

CHURCH V. S.

UN 21 1957

## REGGAE IN FED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6242

## CERTIFICATE OF DEATH

06232

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN lb <i>1</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Play Meus Hoop</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Faulkner</i>				
d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>THOMAS W. BOWLING</i>		First <i>THOMAS</i>	Middle <i>W.</i>			
4. DATE OF DEATH <i>JUNE 4 1957</i>		Month <i>JUNE</i>	Day <i>4</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. B. DATE OF BIRTH <i>Sept 13 1878</i>		9. AGE (In years last birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Wallace T. Bowling</i>				
14. MOTHER'S M AIDEN NAME <i>Ellen Dolman</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				
16. SOCIAL SECURITY NO. <i>420-1</i>		17. INFORMANT <i>Mrs Margaret Cootsey Dentwelle</i>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arterio - renal apoplexy</i>		5 days				
DUE TO <i>Benign prostatic hypertrophy &amp; obstruction</i>		1 yr.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I(a) <i>Bilateral benign prostatic hypertrophy &amp; obstruction</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Debtwelle MD</i>	20f. (City or town) <i>Debtwelle</i>	(County) <i>Charles</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>April</i> , 19 <i>56</i> , to <i>6-4</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6-4</i> , 19 <i>57</i> , and that death occurred at <i>1200</i> M, from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Dr. Johnson</i>				ADDRESS (Street, city or town, state) <i>La Plata, Md. 20552</i>		
PHYSICIAN'S NAME (Type) <i>F. M. Johnson MD.</i>				DATE SIGNED <i>6-5-57</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/7/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Debtwelle ME</i>		22d. LOCATION (City, town, or county) <i>Debtwelle</i>	(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Short fire La Plata Md</i>		ADDRESS <i>W. Short fire La Plata Md</i>	24a. REC'D BY REGISTRAR DATE <i>6/10/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia B. Basye</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED STATE DEPARTMENT OF LABOR - ESTIMONE 18  
CERTIFICATE OF DEATH

BUREAU V. S.

JUN 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6243 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 0217 7-12-57 et

07378  
105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>CHARLES</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>	
d. LENGTH OF STAY IN 1b <i>1</i>		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>JAMES LUTHER BUTLER</i>		First <i>James</i>	Middle <i>Luther</i>
4. DATE OF DEATH <i>6 29 1957</i>		Month <i>6</i>	Day <i>29</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>10-15-1902</i>
9. AGE (in years, months and days) <i>74 yrs.</i>		10. IF UNDER 1 YEAR Months <i>7</i>	11. IF UNDER 24 HRS. Days <i>22</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>what ever available</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John BUTLER</i>		14. MOTHER'S MAIDEN NAME <i>Georgia Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>UNK.</i>	
17. INFORMANT <i>LENNIE Kent 921 N. J Ave. SE</i>		Address <i>Wash. D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6-29-57</i>	
DUE TO <i>983X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Comminuted Fracture of skull</i>		6-29-57	
DUE TO (c) <i>Hit a Club</i>		6-29-57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hit a Club</i>	
20c. TIME OF INJURY Hour <i>7</i> p.m. Month, Day, Year <i>6-29 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>Laurel</i>		(County) <i>Calvert</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. E. DÉLEN</i>		DATE SIGNED <i>7-1-57</i>	
EXAMINER'S NAME (Type) <i>E. J. E. DÉLEN</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>7-3-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>John Wesley Cem.</i>
22d. LOCATION (City, town, or county) <i>Waldorf</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunton Funeral Home</i>		ADDRESS <i>Waldorf, Md.</i>	24a. REC'D BY REGISTRAR <i>18 1957</i>
		24b. REGISTRAR'S SIGNATURE <i>M. L. Monroe</i>	

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
STATE OF NEW YORK - CITY

BUREAU V. S

JUL 8 1957

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-56 1pw

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06233  
106

## CERTIFICATE OF DEATH

Reg. Dist. No.

6244

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Charles</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Rural-Indian Head Md</b>		STATE <b>Maryland</b> LENGTH OF STAY (In this place) <b>6 yrs.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STATE <b>Maryland</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural-Indian Head Md</b> STREET ADDRESS (If rural give location) <b>XO</b>	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
<b>George Carroll Casto</b>		6-8-57	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White-US</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>9-22-1889</b>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if <b>Hospital Attendant</b> )		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical Care</b>	11. BIRTHPLACE (State or foreign country) <b>Morgantown-West Virginia</b>
13. FATHER'S NAME <b>UNK</b>		14. MOTHER'S MAIDEN NAME <b>UNK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>222-07-7578</b>	
17. INFORMANT & ADDRESS <b>Wife-Mrs Geo Casto, Bryans Road Md</b>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<b>162x</b> IMMEDIATE CAUSE <b>General Asthenia</b> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <b>Bronchio-Genic Carcinoma</b> (C) <b>Cerebral Metastases</b>		<b>One Month</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<b>One Year</b>	
III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<b>6-Mths</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) <b>17-Potomac Ave Indian Head Md</b> (State) <b>6-8-57</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>M.</b>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>August-1</b> , 1956, to <b>6-8-57</b> , 19....., that I last saw the deceased alive on <b>6-8-57</b> , 19....., and that death occurred at <b>2:30P.M.</b> from the causes and on the date stated above. SIGNATURE <b>James E. Pendleton</b> M.D. ADDRESS (Street, city, town, state) <b>17-Potomac Ave Indian Head Md</b> DATE SIGNED <b>6-8-57</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 14, 1957</b>	
24. REC'D BY REGISTRAR <b>James E. Pendleton</b>		NAME OF CEMETERY OR CREMATORIAL <b>Pleasant Hill</b>	
DATE <b>JUN 12 1957</b>		LOCATION (City, town, or county) <b>Huron County, Ma</b> (State)	
REGISTRAR'S SIGNATURE <b>Mrs. Odey Price</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>The HORN Funeral Home</b>	
ADDRESS		ADDRESS <b>Waldorf</b>	

DEPARTMENT OF JUSTICE - STATE OF TEXAS

STATE OF TEXAS

RECEIVED

TEXAS DEPARTMENT OF JUSTICE

RECEIVED

BUREAU V. S.

JUN 12 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06234

6245

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	CHARLES LA Plata PHYSICIANS MEMORIAL	MARYLAND LENGTH OF STAY (In this place) 2 days	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS 1	Md Wicomico (If rural give location)	COUNTY charles
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH 6 - 8 - 57 19	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH OCT 19 1895	9. AGE last birthday 61	IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (State or foreign country) CHARLES County, Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME ROBERT LEE CLEMENTS		14. MOTHER'S MAIDEN NAME FLORENCE THOMPSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS MARY L. Clements Wicomico, Md.	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 153X IMMEDIATE CAUSE (A) INTESTINAL OBSTRUCTION ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) NEOPLASTIC PERITONITIS GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) ADENOCARCINOMA OF APPENDIX INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 3 MOS. 14 MOS.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION 6-7-57		19b. MAJOR FINDINGS OF OPERATION EXTENSIVE ADENOCARCINOMA - ABDOMEN		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from APRIL 19, 56, to JUNE 8, 1957, that I last saw the deceased alive on JUNE 8, 1957, and that death occurred at 6:00 P.M., from the causes and on the date stated above. SIGNATURE S. Parran Jarboe M.D. ADDRESS (Street, city, town, state) La Plata Md. DATE SIGNED 6-8-57					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-11-57		NAME OF CEMETERY OR CREMATORIAL ST MARY'S CEM.	
24. REC'D BY REGISTRAR DATE JUN 12 1957		REGISTRAR'S SIGNATURE Julia P. Pugh		LOCATION (City, town, or county) NEWPORT, Md. ADDRESS Huntt Funeral Home WALDOOF, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home WALDOOF, Md.					

BY ADDITIONAL AUTHORITY OF NEARLY-UNIVERSAL STATE CHAIRMEN

CERTIFICATE OF DEATH

104-1470-2440

DECEASED - JOHN HENRY COOPER, JR.

DECEASED - JOHN HENRY COOPER, JR.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1140	1141	1142	1143	114

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. A15ME(5)  
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MEDICAL CERTIFICATION

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06235

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRYANTOWN		c. LENGTH OF STAY IN 1b 16 YRS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WARREN LEVI DENT		4. DATE OF DEATH JUNE 12 1957	Month Day Year			
5. SEX MALE	6. COLOR OR RACE W-U.S.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20, 1875			
9. AGE (in years last birthday) 82 yr.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. CIVIL SERVICE	10b. KIND OF BUSINESS OR INDUSTRY FOREMAN	11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.	13. FATHER'S NAME FREDERICK DENT					
14. MOTHER'S MAIDEN NAME MARY DENT	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO					
16. SOCIAL SECURITY NO. —	17. INFORMANT MRS. WARREN DENT: BRYANTOWN, MD	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO HEART Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIO-SCLEROSIS DUE TO FAILURE						
INTERVAL BETWEEN ONSET AND DEATH INSTANTANEOUS 20 YRS.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) —	(County) —	(State) —
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE John N. Griffin	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) acting			DATE SIGNED 6/12/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 15, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Old Fields	22d. LOCATION (City, town, or county) Highlandtown (State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE		
Hennet Funeral Home Waldorf, Md.		DATE JUN 17 1957	Julia Posey			

DEPARTMENT OF HEALTH - SANITATION - MEDICAL EXAMINER - CERTIFICATE OF DEATH

NAME

ADDRESS

PHONE

AGE

SEX

WEIGHT

HEIGHT

HAIR COLOR

EYE COLOR

HAIR LENGTH

HAIR THICKNESS

HAIR DENSITY

HAIR TYPE

HAIR SHAPE

HAIR STYLING

HAIR COLOR

HAIR SHAPE

HAIR STYLING

BUREAU V. 2

JUN 17 1957

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 34 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06236

## CERTIFICATE OF DEATH

6247

Item 7 Film G216 6-19-57 et

Reg. Dist. No. 100

## 1. PLACE OF DEATH

COUNTY Charles  
 CITY (If outside corporate limits, write RURAL  
 OR end give nearest town)  
 TOWN Laurel

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Physicians Memorial Hospital

MARYLAND  
 LENGTH OF STAY  
 (in this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Charles  
 CITY (If outside corporate limits, write RURAL end give nearest town)  
 TOWN Bryans Road, Md.  
 STREET ADDRESS (If rural give location)

3. NAME OF  
 DECEASED  
 (Type or Print)(First) William A. Dyson  
 (Middle)

(Last) Dyson

4. DATE (Month) (Day) (Year)  
 OF DEATH June 15 1957

5. SEX male

6. COLOR OR  
 RACE Col.7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify) Widowed

8. DATE OF BIRTH

9. AGE last birthday  
 78 yrs.IF UNDER 1 YEAR  
 Months Days Hours Min.10e. USUAL OCCUPATION (Give kind of work  
 done during most of working life, even if  
 retired) retired10b. KIND OF BUSINESS  
 OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT  
 COUNTRY? U. S.

13. FATHER'S NAME

Sidney Dyson

14. MOTHER'S MAIDEN NAME

Sophie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
 (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

Hattie L. King Wash. D. C.

INTERVAL BETWEEN  
 ONSET AND DEATH

5 day

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) \_\_\_\_\_  
 ANTECEDENT CAUSE(S) DUE TO \_\_\_\_\_DISEASES OR CONDITIONS, IF ANY, (B) \_\_\_\_\_  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST. DUE TO \_\_\_\_\_  
 (C) \_\_\_\_\_II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO 21a. ACCIDENT WAS UNDERLYING   
 OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
 While  
 M. at work  Not while  
 at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 a.m., 19 57, to 15 a.m., 19 57, that I last saw the deceased  
 alive on 14 Jun 1957, and that death occurred at 8:25 a.m., from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

24. REC'D. BY REGISTRAR

DATE JUN 17 1957

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

14

Julia Tracey

Barnes &amp; Matthews 614-4850

81. COMM-FBI-REF ID: A65440 STATE DEPARTMENT

STAGE 50 REACHES

1950-1951

REF ID: A65440

REF ID: A65440

RECEIVED

BUREAU V. S.

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6248 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06237

Reg. Dist. No. 106

1. PLACE OF DEATH a. COUNTY <b>Charles</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2 Potomac Heights</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Dispensary Indian Head Md</b>			d. STREET ADDRESS <b>156 Elder Place</b>		
3. NAME OF DECEASED (Type or print) <b>Edward Milton Forrestell</b>			4. DATE OF DEATH <b>June 13 1957</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-5-96</b>	9. AGE (In years last birthday) <b>61 yrs.</b>	10. IF UNDER 1YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Catering Service</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Civ. Serv. (Ret)</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>William Forrestell</b>			14. MOTHER'S MAIDEN NAME <b>Not Known</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16. SOCIAL SECURITY NO. <b>220 326 172</b>		
17. INFORMANT PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b>			Address <b>Mrs E. Forrestell, Indian Head Md.</b>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>471.2</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>		
DUE TO <b>(b)</b>			24 hrs.		
DUE TO <b>(c)</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Had Coronary Occlusion 2 years ago and was under treatment</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) <b>Herb 18</b>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Frank A. Susan</b>			DATE SIGNED <b>6-13-57</b>		
EXAMINER'S NAME (Type) <b>Frank A. Susan M.D.</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/19/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Natl.</b>	
22d. LOCATION (City, town, or county) <b>Arlington Va.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Wash. D.C.</b>			24a. REC'D BY REGISTRAR DATE <b>4/13/57</b>		
			24b. REGISTRAR'S SIGNATURE <b>Odey Price</b>		

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUN 25 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6249 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06238  
100

1. PLACE OF DEATH a. COUNTY	Charles		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE	Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b	b. COUNTY	
Rural Replay		1 yr.		Chesapeake	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		

e. IS RESIDENCE  
ON A FARM?  
YES  NO

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
SANDRA	R	Robin	GilRoy	5-31-56	6	26	1957	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5-31-56	yrs.	Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
--	-----------------------------------	---	------------------------------

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
Floyd Collins Gilroy	Dorothy Mae Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		6-26-57
830x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Crushed skull
(b) DUE TO		6-26-57
(c) DUE TO		Truck ran over her

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	---

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 20.)				
20c. TIME OF INJURY Month, Day, Year 4 p.m. 6-26-57	20d. INJURY OCCURRED White or work <input type="checkbox"/> Not white or work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, office, office bldg., etc.) Home	20f. (City or town) Replay	(County) Chesapeake	(State) Md

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
--	--	--	--	--	--

ACTUAL SIGNATURE	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
E. J. EDILIAN	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		6-26-57
EXAMINER'S NAME (Type)	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL McKee	22d. LOCATION (City, town, or county) La Plata	(State) Md
Funeral	6-29-57			
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR Julia H. Paasch	24b. REGISTRAR'S SIGNATURE	
Archibald Jr. La Plata Md		DATE 7/1/57	Julia H. Paasch	

BUREAU V. 8

3 1957

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06239

## CERTIFICATE OF DEATH

6250

Reg. Dist. No. 100

## 1. PLACE OF DEATH

COUNTY *Parker Co*CITY (If outside corporate limits, write RURAL  
OR end give nearest town)TOWN *Laytonsville*HOSPITAL  
INSTITUTION OR  
STREET ADDRESS  
*Playmore Motel*

MARYLAND

LENGTH OF STAY  
(in this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

COUNTY *Charles*

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN *Bethesda*STREET  
ADDRESS

(If rural give location)

3. NAME OF  
DECEASED

(Type or Print)

(First) *Infant*

(Middle)

(Last)

4. DATE  
OF  
DEATH

(Month) (Day) (Year)

*June 14*

19 57

5. SEX *Male*6. COLOR OR  
RACE *Col*10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

8. DATE OF BIRTH

*June 13 1957*

9. AGE last birthday

IF UNDER 1 YEAR  
Months *0* Days *0* Hours *0* Min. *0*10. KIND OF BUSINESS  
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Charles Co Md.*12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME

*Leonard Harvey*

## 14. MOTHER'S MAIDEN NAME

*Ann Willis*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)

(If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

*123-45-6789*

## 17. INFORMANT &amp; ADDRESS

*Leonard Harvey*

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

764.0 IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

## 18. MEDICAL CERTIFICATION

*Infant diarrhea*INTERVAL BETWEEN  
ONSET AND DEATH*6-14-57*

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
M. While at work  Not while at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.

SIGNATURE *J. L. DeLoach* ADDRESS (Street, city, town, state) DATE SIGNED23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Buried

DATE THEREOF

6-17-57

NAME OF CEMETERY OR CREMATORIAL

Anne Property

LOCATION (City, town, or county)

(State)

Bel Air, Md.

24. REC'D BY REGISTRAR

DATE *6/18/57*

REGISTRAR'S SIGNATURE

Julia H. Posey

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

4000 141 XVII

RECEIVED IN THE  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
AT THE  
FEDERAL BUREAU OF INVESTIGATION

FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

JUN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06240

Reg. Dist. No.

105

1. PLACE OF DEATH a. COUNTY <i>Charles</i> <b>MARYLAND</b>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>not</i> b. COUNTY <i>Charles</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Plains</i>	c. LENGTH OF STAY IN 1b <i>1 week</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>White Plains</i>	d. STREET ADDRESS <i>—</i>				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>LARRY</i>	First <i>ELROY</i>	Middle <i>HAWKINS</i>	Last <i>—</i>	4. DATE OF DEATH Month <i>6</i> Day <i>28</i> Year <i>57</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>—</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>6-28-19</i>	9. AGE (In years last birthday) yrs. <i>—</i>	10. IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i>	11. IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>white Plains and Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>white Plains and Md</i>		
13. FATHER'S NAME <i>WALKER A H. HAWKINS</i>	14. MOTHER'S MAIDEN NAME <i>EDNA CAMPBELL</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>7620</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Warren Hawkins</i>	Address <i>white Plains and Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration of Tonites</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>7620</i> (b) DUE TO (c) Aspiration of Tonites			INTERVAL BETWEEN ONSET AND DEATH <i>6-28-57</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>—</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>				
20c. TIME OF INJURY Hour <i>6</i> p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>White Plains</i>	20f. (City or town) <i>White Plains</i>	(County) <i>Charles</i>	(State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <i>Actual Signature</i> <i>E. J. Edelen</i>					
ACTUAL SIGNATURE <i>E. J. Edelen</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>6-28-57</i>
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/29/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Joseph</i>	22d. LOCATION (City, town or county) <i>Baltimore</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>	ADDRESS <i>1000 310 XV6</i>	24a. REC'D BY REGISTRAR DATE <i>JUL 2 1957</i>	24b. REGISTRAR'S SIGNATURE <i>M. L. Monroe</i>		

RECEIVED - EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. A.

JUL 2 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6252

## CERTIFICATE OF DEATH

Reg. Dist. No. 06241

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DONALD LEE HOOD		First	Middle
4. DATE OF DEATH JUNE 15 1957		Month	Day
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH FEB. 6 1945		9. AGE (In years last birthday) 12 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) school		10b. KIND OF BUSINESS OR INDUSTRY school	
10c. 11. BIRTHPLACE (State or foreign country) JAMES HOOD		12. CITIZEN OF WHAT COUNTRY? MAE PEARSON	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT None MRS. MAE GORDON	
18. DUE TO PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 145 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		19. ADDRESS WALDORF, MD.	
18. DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) Carcinomatosis (c) Cancer of Primary of Lungs		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 15, 1950, to June 15, 1957, that I last saw the deceased alive on June 15, 1957, and that death occurred at Waldorf, Md., from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) Waldorf, Md. DATE SIGNED 6-17-57	
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-18-57	
22c. NAME OF CEMETERY OR CREMATORIUM St. Pauls Cemetery		22d. LOCATION (City, town, or county) Waldorf, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home		24a. RECEIVED BY REGISTRAR DATE JUN 19 1957	
		24b. REGISTRAR'S SIGNATURE M. L. Monroe	

## CERTIFICATE OF DEATH

NAME OF DEATH

DATE OF DEATH

BUREAU OF INVESTIGATION

JUN 19 1957

RECEIVED

1 Items 2&18 Film 2187-26-57 ans MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06242

Reg. Dist. No.

105

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Charles		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY -- Charles Pr. Geo.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		16X0-2		
d. STREET ADDRESS						d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First EUGENE	Middle CLARENCE	Last INGRAHAM	4. DATE OF DEATH	Month June	Day 19	Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/2/1912	9. AGE (in years last birthday) 41 yrs.	10. IF UNDER 1YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.				
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parts Clerk		10b. KIND OF BUSINESS OR INDUSTRY Auto		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Edward D. Ingraham				14. MOTHER'S MAIDEN NAME Emma L. Tower						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no 578 01 2008		17. INFORMANT Mireta R. Ingraham		Address 1606 17st, SE Wash., D. C.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fatty Liver</u> DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Paul F. Guerin</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED 6/19/57	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-22-57	22c. NAME OF CEMETERY OR CREMATORIAL St Paul's	22d. LOCATION (City, town, or county) Waldorf, Md.	(State)						
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf, Md.	24a. REC'D BY REGISTRAR JUN 25 1957	24b. REGISTRAR'S SIGNATURE <i>M. L. Monroe</i>						
			DATE							

REGULAR EXAMINER CERTIFICATE OF DEATH  
REGULAR EXAMINER CERTIFICATE OF DEATH

BUREAU V. A

JUN 25 1957

RECEIVED

N

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6254 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 FilmG217 7-12-57 et

07384

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Charles. MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mc Victoria		c. LENGTH OF STAY IN 1b 1/2 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. STREET ADDRESS 1506 "R" St., N. W.		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Ric HARD		E	Jones
4. SEX M		5. COLOR OR RACE C	6. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		7. DATE OF BIRTH Aug 6 1919	
8. AGE (In years for birthday 37 yrs.)		9. IF UNDER 1YEAR Months	10. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer Dept		10b. KIND OF BUSINESS OR INDUSTRY Ac. Corp	
10c. BIRTHPLACE (State or foreign country) LT		11. CITIZEN OF WHAT COUNTRY? Address	
12. FATHER'S NAME Richard E. Jones Jr.		13. MOTHER'S MAIDEN NAME Margaret Leslie Brown	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		15. SOCIAL SECURITY NO.	
16. INFORMANT		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 850.X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Drowning Capsized Boat			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat Capsized	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
6-30-57		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boat	
		20f. (City or town) McComas River, Md.	
		(County)	
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE F. J. Edelen		DATE SIGNED 7-4-57	
EXAMINER'S NAME (Type) F. J. Edelen		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-5-57	
22c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet		22d. LOCATION (City, town, or county) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Arehart Joe Soplets, Md.		24a. REC'D BY REGISTRAR DATE 7/6/57	
		24b. REGISTRAR'S SIGNATURE Julia H. Parey	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06243

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury		c. LENGTH OF STAY IN 1b 1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) GEORGE		First Middle (Simons)	4. DATE OF DEATH Last Month Day Year MADDOX June 16 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED JUN 9 1932	9. AGE (in years last birthday) 20 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherwoman			
10b. KIND OF BUSINESS OR INDUSTRY Fishing		11. BIRTHPLACE (State or foreign country) England				
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Simons				
14. MOTHER'S MAIDEN NAME Elizabeth Maddox		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO.		17. INFORMANT Joseph Simons Marbury 2nd				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning, Found Drowned. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Found drowned.						
20c. TIME OF INJURY Hour 3:00 p.m.	Month, Day, Year 6/15 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mattawoman Creek	20f. (City or town) Near Indian Head	(County) Charles	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .						
ACTUAL SIGNATURE Paul F. Guerin, M.D.				DATE SIGNED 6/17/57		
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6/18/57		22b. DATE THEREOF 6/18/57		22c. NAME OF CEMETERY OR CREMATORIAL Smiths Chapel		22d. LOCATION (City, town, or county) Bryant
23. FUNERAL DIRECTOR'S SIGNATURE Richard Lee Caplano		ADDRESS 1000		24a. REC'D BY REGISTRAR Julia M. Rosey		24b. REGISTRAR'S SIGNATURE Julia M. Rosey

MANHATTAN PROJECT - DIVISION OF MEDICAL EXAMINER - CERTIFICATE OF DEATH

BUREAU V. S.

JUN 21 1957

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06244

## 6258 CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)		CHARLES MARYLAND LENGTH OF STAY (In this place)		STATE Maryland		COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		
TOWN Indian Head				XO		CHARLES Indian Head (If rural give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS				
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)				
William Joseph MATTINGLY				June 26, 1957				
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 10, 1872	9. AGE last birthday 85	IF UNDER 1 YEAR yrs.	IF UNDER 24 HRS. Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Retired U.S. Gov.)			10b. KIND OF BUSINESS OR INDUSTRY Ret.			11. BIRTHPLACE (State or foreign country) New York		
13. FATHER'S NAME John T. Mattingly				14. MOTHER'S MAIDEN NAME Eliz. E. Franklin				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No.				16. SOCIAL SECURITY NO.				
17. INFORMANT & ADDRESS Mary E. Mattingly Indian Head, Md.								
18. MEDICAL CERTIFICATION								
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								
420.0 IMMEDIATE CAUSE (A) Respiratory failure ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Cerebral vascular accident GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) Anterior sclerosis heart disease								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.								
19e. DATE OF OPERATION 3/1/57		19b. MAJOR FINDINGS OF OPERATION						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? EST ADDRESS (Street, city, town, state) La Plata, Md. 26 Jan 57				
22. I hereby certify that I attended the deceased from May 19, 1957, to June 19, 1957, that I last saw the deceased alive on June 19, 1957, and that death occurred at 12:20 P.M. from the causes and on the date stated above. SIGNATURE J. W. Wood								
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-29-57		NAME OF CEMETERY OR CREMATORIAL St Joseph's Cem.		LOCATION (City, town, or county) Pomfret, Md.		
24. REC'D BY REGISTRAR DATE JUL 1 1957		REGISTRAR'S SIGNATURE Oley Pricey		25. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home Waldorf, Md.				

STATE GOVERNMENT OF HAWAII - HAWAII

STATE CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G216 6-17-21 et

06049  
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Patapsco Md</i>		c. LENGTH OF STAY IN 1b <i>4 hrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Ortho Med. Hosp</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severnsville 16152</i>	
d. STREET ADDRESS <i>7509-25th Ave</i>		d. DATE OF DEATH Month Day Year <i>6 8 1957</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>MARGARET</i>		4. DATE OF DEATH Month Day Year <i>6 8 1957</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 7 1916</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (in years (and birthday) <i>80 60</i>		10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) <i>W. Va. USA</i></i>	
13. FATHER'S NAME <i>Lloyd C McCauley</i>		14. MOTHER'S MAIDEN NAME <i>Betty Bosella Stewart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>816X</i>		16. SOCIAL SECURITY NO. <i>577-42-6103</i>	
17. INFORMANT <i>Glenn A. Mc Nannis</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO <i>Abdominal hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Multiple lacerations and contusions</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>6-8-57</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Auto accident</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>2 car auto accident</i>	
20c. TIME OF INJURY Month, Day, Year <i>Aug 6 1957</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>301 Highway</i>		20f. (City or town) <i>Mildred Ches. Md.</i>	
		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED <i>6-8-57</i>	
ACTUAL SIGNATURE <i>E. J. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. Edelen</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-13-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St. J. Lincoln</i>		22d. LOCATION (City, town, or county) <i>Colmar Manor Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home - Washington</i>		24a. REC'D BY REGISTRAR <i>Julia Posy</i>	
ADDRESS <i>1212 12th Street N.W. Washington D.C. 20530</i>		24b. REGISTRAR'S SIGNATURE <i>Julia Posy</i>	

STATE OF MARYLAND  
MEDICAL EXAMINER'S OFFICE

BUREAU V. S

JUN 12 1957

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-57 10/1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06245

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Charles CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN La Plata Md		MARYLAND LENGTH OF STAY (in this place) 3-days	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hosp. La Plata Md.		STATE Maryland COUNTY Charles CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head Md.	
3. NAME OF DECEASED (Type or Print) Dora Posey		4. DATE (Month) (Day) (Year) OF DEATH 6-14-57 19	
5. SEX F.	6. COLOR OR RACE W-US	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <input checked="" type="checkbox"/> Single	8. DATE OF BIRTH 2-13-1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Charles County Maryland
13. FATHER'S NAME Charles Henry Posey		14. MOTHER'S MAIDEN NAME Susan Julia Posey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Doris Morgan Hedges, 14-E-60th St. New York City		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Coronary Heart Disease ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Arterio-Sclerosis GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Senility	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		19. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10-Yrs	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 1954 to 6-14-57, 19....., that I last saw the deceased alive on 6-14-57, 19....., and that death occurred at 5-15 PM from the causes and on the date stated above. SIGNATURE James E. Andrews MD. M.D. ADDRESS (Street, city, town, state) DATE SIGNED 6-15-57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) General		DATE THEREOF 6-17-57	NAME OF CEMETERY OR CREMATORIAL St. Charles
24. REC'D BY REGISTRAR DATE 6/18/57		REGISTRAR'S SIGNATURE Julia H. Posey	LOCATION (City, town, or county) Indian Head Md
25. FUNERAL DIRECTOR'S SIGNATURE Cecil Hartman La Plata No		ADDRESS	

BUREAU V.

21 JUN 1957

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**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6259 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06246  
Print. No. 100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>So. Carol.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Georgetown</i>		c. LENGTH OF STAY IN 1b <i>1 mos.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>LeRoy</i>		First <i>Reed</i>	Middle <i>Reed</i>
4. SEX <i>M</i>	5. COLOR OR RACE <i>C</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>8-24-29</i>
8. AGE (in years last birthday) <i>27</i>	9. IF UNDER 1 YEAR Months <i>6</i>	10. IF UNDER 24 HRS. Days <i>14</i>	11. IF UNDER 24 HRS. Hours <i>19</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>	11. BIRTHPLACE (State or foreign country) <i>Georgetown S.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>James Reed</i>		14. MOTHER'S MARRIED NAME <i>Louise Conyer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Type no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Penicillag</i>			
982X DUE TO <i>Stab wound of chest</i>			
Conditions, if any, which gave rise to immediate cause (b) <i>Causing one of the glut</i>			
DUE TO (c) <i>hand or heel</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>Stabbed by assailant</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, hotel, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>Georgetown</i>		(County) <i>So. Carol.</i>	(State) <i>SC</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		DATE SIGNED <i>6-15-57</i>	
EXAMINER'S NAME (Type) <i>E. J. Edelen M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>6-20-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Georgetown</i>		22d. LOCATION (City, town, or county) <i>Georgetown S.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard Lee L. V. Vlakas</i>		24a. REC'D BY REGISTRAR DATE <i>6/20/57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Julia W. Pasey</i>	

RECEIVED  
BUREAU V. S.

JUN 24 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06247

## 6260 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ohio</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Spring Hill</i>		c. LENGTH OF STAY IN 1b <i>1b</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Defiance</i>		d. STREET ADDRESS <i>725 Wayne Ave</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>None</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Thomas Michael Ryan</i>		First <i>Thomas</i>	Middle <i>Michael</i>
4. DATE OF DEATH Month <i>6</i>		Year <i>1957</i>	Day <i>8</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>1948-31</i>	9. AGE (in years last birthday) <i>25 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gas.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S.A.F.</i>	11. BIRTHPLACE (State or foreign country) <i>None</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Daniel Francis Ryan</i>	
14. MOTHER'S MAIDEN NAME <i>Leona Margaret</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	
16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Capt. T. E. Bell</i>	Address <i>Billing a. 7. Room 501</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Fracture skull</i>			
DUE TO <i>air crushed chest</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>auto accident</i>			
DUE TO (c) <i>auto accident</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Car collision, auto</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Car collision, auto</i>	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>At 301</i>
20f. (City or town) <i>None</i>		(County) <i>None</i>	
(State) <i>None</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		DATE SIGNED <i>6-8-57</i>	
EXAMINER'S NAME (Type) <i>E. J. Edelen M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-10-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Defiance</i>
22d. LOCATION (City, town, or county) <i>Defiance, Ohio</i>		(State) <i>Ohio</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers Co.</i>		ADDRESS <i>517-11th St. S.E.</i>	
24a. REC'D. BY REGISTRAR <i>UNI 12 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Julia Posey</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEPARTMENT OF STATE BUREAU OF INVESTIGATION - CALIFORNIA  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUN 12 1957

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06248

6261

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Charles		MARYLAND		STATE Maryland COUNTY Charles	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
TOWN La Plata		XO		Rock Point, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
Physicians Memorial Hospital			(If rural give location)		
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year)		
John W. Shorter			June 14 1957		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower	8. DATE OF BIRTH Sept 30 1873	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. farmer			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	IF UNDER 24 HRS. Days Hours Min.
13. FATHER'S NAME John W. Shorter			14. MOTHER'S MAIDEN NAME Elizabeth Long		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		
(If Yes, give war or dates of service)			17. INFORMANT & ADDRESS Mary Nichols Washington D.C.		
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Congestive heart failure age 77 Hypertension					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
M.			21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above. SIGNATURE <i>Aileen</i> M.D.					
23. BURIAL, CREMATION, REMOVAL (Specify) Burial			DATE THEREOF 6/17/57		
NAME OF CEMETERY OR CREMATORIAL Holy Ghost			LOCATION (City, town, or county) Issue and		
24. REC'D BY REGISTRAR Julia H. Posey			25. FUNERAL DIRECTOR'S SIGNATURE C. H. H. Posey		
DATE 6/8/57			ADDRESS		

UNITED STATES GOVERNMENT - STATE DEPARTMENT

CERTIFICATE OF DEATH

RECEIVED  
BUREAU V. S.  
JUN 21 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07392  
702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Iron sides</i>	c. LENGTH OF STAY IN 1b <i>XO</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Iron sides</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Lawrence E. Stafford</i>	First <i>Lawrence</i>	Middle <i>E.</i>	Last <i>Stafford</i>
4. DATE OF DEATH <i>6 20 57</i>	Month <i>6</i>	Day <i>20</i>	Year <i>57</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 23, 1904</i>
9. AGE (In years at birthday) <i>53</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Writer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Financial</i>	11. BIRTHPLACE (State or foreign country) <i>Minnesota</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Harry H. Stafford</i>	14. MOTHER'S MAIDEN NAME <i>Edith Bayley</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>363-05-3857</i>	17. INFORMANT <i>Mary M. Stafford (Wife), Ironsides, Md.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cardiovascular Occlusion</i> INTERVAL BETWEEN ONSET AND DEATH <i>6-20-57</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <i>7/3/57</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Ed Edelen</i>	DATE SIGNED <i>6-30-57</i>		
EXAMINER'S NAME (Type) <i>Ed Edelen</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/3/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph M. Thompson</i>	ADDRESS <i>1756 Pennsylvania Ave NW, Washington, DC</i>	24a. REC'D BY REGISTRAR <i>July 5 1957</i>	24b. REGISTRAR'S SIGNATURE <i>V Thompson</i>

REGULAR EXAMINATIONS SHOULD BE HELD AT LEAST ONCE A MONTH.

## BUREAU V. S.

JUL 8 1957

REGELIV ED

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06249

6263

## CERTIFICATE OF DEATH

100

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY

Charles

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR end give nearest town)

TOWN

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Bryans Road

LENGTH OF STAY  
(in this place)

20 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Md.

COUNTY

Charles

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

Bryans Road

STREET  
ADDRESS

(If rural give location)

3. NAME OF  
DECEASED

(Type or Print)

(First) Robert

(Middle)

(Last)

Thomas

4. DATE (Month)  
OF DEATH

(Day)

(Year)

June 2

1957

## 5. SEX

Male

6. COLOR OR  
RACE

Colored

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Farmer

10b. KIND OF BUSINESS  
OR INDUSTRY7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Widowed

8. DATE OF BIRTH

March 17, 1848

109

9. AGE last birthday  
yrs.

## 13. FATHER'S NAME

Not Known

## 14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)

(If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

None

## 17. INFORMANT &amp; ADDRESS

Gracie Thomas, Washington DC

## 18. MEDICAL CERTIFICATION

331X IMMEDIATE CAUSE

(A)

Cerebral Hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH  
3wks.

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY  
YES  NO 21a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M. While at work  Not white at work 22. I hereby certify that I attended the deceased from July 8, 1957, to June 2, 1957, that I last saw the deceased  
alive on July 1, 1957, and that death occurred at 8 P.M. from the causes and on the date stated above.

SIGNATURE

Frank A. Pasey M.D. Indian Head, Md. DATE SIGNED 6-2-57

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORI

## LOCATION (City, town, or county)

(State)

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

## DATE

JUN 7 1957

Julia Posey

Hunt Fondue Home Waldorf

Md.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6264 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06250  
*100*

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY <i>Charles</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>En-route to La Plata</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO McConchie</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Auto enroute</i>			d. STREET ADDRESS --		
3. NAME OF DECEASED (Type or print) <i>Elvynne</i>		First <i>Elvynne</i>	Middle <i></i>	Last <i>Thomas</i>	4. DATE OF DEATH Month <i>6</i> Day <i>3</i> Year <i>1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-14-57</i>		9. AGE (In years last birthday) yrs. <i>1</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>McConchie, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Elvyn Thomas</i>			14. MOTHER'S MAIDEN NAME <i>Mary Florence Brown</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Elvyn Thomas</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: <i>571.0</i> IMMEDIATE CAUSE (a) <i>Due to</i> Conditions, If any, which gave rise to immediate cause (b) <i></i> (a), <u>storing the underlying cause last</u> (c) <i></i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	
20f. (City or town) <i></i> (County) <i></i> (State) <i></i>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>R. Geddes</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>6-3-57</i>	
EXAMINER'S NAME (Type) <i>F. J. Geddes</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Own of Richard Thomas</i>	
22d. LOCATION (City, town, or county) <i>McConchie</i> (State) <i>Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Reharts Inc.</i>			ADDRESS <i>Seaford and Lapeletta</i>		
24a. REC'D BY REGISTRAR <i>6/10/57</i>			24b. REGISTRAR'S SIGNATURE <i>Julia K. Passy</i>		

SURVEAU V. S

JUN 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06251 100			
6265 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY Charles MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville (Rural)		c. LENGTH OF STAY IN 1b 0			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville (Rural)								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First MARY	Middle	Lost Toye	4. DATE OF DEATH 6 - 9	Month	Day	Year 19 57					
5. SEX F		6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1903	9. AGE (In years last birthday) 54 yrs.	10. IF UNDER 1YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maid			10b. KIND OF BUSINESS OR INDUSTRY domestic		11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William W. Toye					14. MOTHER'S MAIDEN NAME Jane Estep De Sales B. Toye, Hughesville, Md. Address								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)										16. SOCIAL SECURITY NO. unk	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) STAB Wound of AORTA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .										DATE SIGNED 6/9/57			
ACTUAL SIGNATURE R. S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) R. S. FISHER													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-12-57		22c. NAME OF CEMETERY OR CREMATORIAL St Mary's Cem.		22d. LOCATION (City, town, or county) Bryantown, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE 6/12/57		24b. REGISTRAR'S SIGNATURE Julia Pooley							
VS. A15ME(5) 5M 9/55													

BUREAU V.

JUN 13 1957

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06252

6266

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CHARLES	MARYLAND	STATE MARYLAND	COUNTY CHARLES
CITY (If outside corporate limits, write RURAL OR end give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN LA PLATA	XO	OR TOWN LA PLATA	OR TOWN LA PLATA
HOSPITAL OR INSTITUTION OR STREET ADDRESS PHYSICIANS' MEMORIAL HOSPITAL	STREET ADDRESS 1	(If rural give location) WICOMICO STREET	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) MARY		(Middle) BERNADETTE WALKER	
5. SEX FEMALE	6. COLOR OR RACE W-U.S.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH JUNE 26, 1957
9. AGE (at birthday) — yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME THOMAS JEFFERSON WALKER		14. MOTHER'S MAIDEN NAME ESTELLA ELIZABETH HUNTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> <u>      </u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>      </u> <u>      </u> <u>      </u>	
17. INFORMANT & ADDRESS THOMAS J. WALKER LA PLATA, MD.		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>761.5 IMMEDIATE CAUSE</u> (A) <u>EXCESSIVE PREMATURITY (EDC-10/12/57)</u> <u>34 hrs</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <u>MALDEVELOPMENT OF CENTRAL NERVOUS</u> <u>34 hrs</u> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO SYSTEM			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>MARGINAL PLACENTA PREVIA (MATERNAL)</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) <u>Highmeadle Ind.</u> (County) <u>Highmeadle Ind.</u> (State) <u>MD</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>6/28/57</u> 1957 12:00 M.	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>at work</u>	
22. I hereby certify that I attended the deceased from <u>6/27/57</u> , 1957, to <u>6/28/57</u> , 1957, that I last saw the deceased alive on <u>6/28/57</u> , 1957, and that death occurred at <u>6:28 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>John W. Giffen</u> M.D. ADDRESS <u>Highmeadle Ind.</u> DATE SIGNED <u>6/28/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-28-57</u> NAME OF CEMETERY OR CREMATORIY <u>St Peters Cem.</u> LOCATION (City/town, or county) <u>WALDORF, MD.</u> (State) <u>MD</u>	
24. REC'D BY REGISTRAR <u>JUL 1 1957</u>		REGISTRAR'S SIGNATURE <u>Julia Posey</u> 25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u> ADDRESS <u>WALDORF, MD.</u>	

2066263XVO

CERTIFICATE OF DEATH

NAME OF DECEASED: **JOHN H. BROWN**

NAME OF PERSON SIGNING: **JOHN H. BROWN**

RELATIONSHIP TO DECEASED: **SON**

ADDRESS: **1234 BROADWAY, NEW YORK, N.Y.**

PHONE NUMBER: **212-555-1234**

AGE: **45**

SEX: **MALE**

CAUSE OF DEATH: **SHOT DEATH**

TIME OF DEATH: **10:00 P.M.**

PLACE OF DEATH: **1234 BROADWAY, NEW YORK, N.Y.**

TIME OF REPORT: **11:00 P.M.**

NAME OF POLICE OFFICER: **JOHN H. BROWN**

DEPARTMENT: **FEDERAL BUREAU OF INVESTIGATION**

ADDRESS: **1234 BROADWAY, NEW YORK, N.Y.**

PHONE NUMBER: **212-555-1234**

AGE: **45**

SEX: **MALE**

CAUSE OF DEATH: **SHOT DEATH**

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ADDRESS: **1234 BROADWAY, NEW YORK, N.Y.**

PHONE NUMBER: **212-555-1234**

BUREAU OF INVESTIGATION

JUL 1 1957

RECEIVED

RECEIVED JUL 1 1957 FBI-BALTIMORE  
THREE BUREAU LETTERS

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06253

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH

COUNTY Charles

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR  
TOWN and give nearest town)

La Plata

LENGTH OF STAY  
(In this place)HOSPITAL  
INSTITUTION OR  
STREET ADDRESS

Physicians Memorial Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY

Charles

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

Potomac Heights, Md.

STREET  
ADDRESS

(If rural give location)

3. NAME OF  
DECEASED  
(Type or Print)

JOSEPH WILLIAM

(Last)

WHITE

4. DATE  
(Month)  
OF  
DEATH

(Day)

(Year)

June 12 1957

5. SEX

male

6. COLOR OR  
RACE

col

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)10b. KIND OF BUSINESS  
OR INDUSTRY

8. DATE OF BIRTH

April 18/57

9. AGE last birthday

XXXXXX

yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Deys

Hours

Min.

13. FATHER'S NAME

Lawrence White

14. MOTHER'S MAIDEN NAME

Alice Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

571.0 IMMEDIATE CAUSE

(A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. (B)

DUE TO

(C)

## 18. MEDICAL CERTIFICATION

diarrhea &amp; dehydration

pneumonia

INTERVAL BETWEEN  
ONSET AND DEATH

10 days

3 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  OR  
CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month)

(Day)

(Year)

(Hour)

M.

21e. INJURY OCCURRED  
While  
at work  Not while  
at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-12 1957, to 6-12 1957, that I last saw the deceased alive on 6-12 1957, and that death occurred at 949 M, from the causes and on the date stated above.

SIGNATURE

Johnson

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE 6/12/57

4000297XV6

3. BOMBS-NFLAEN TO THE STATE QUARTER

RECEIVED BY THE  
FEDERAL BUREAU OF INVESTIGATION

140-448

RECEIVED BY THE FEDERAL BUREAU OF INVESTIGATION

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140-448  
140-448

RECEIVED BY THE FEDERAL BUREAU OF INVESTIGATION

BUREAU V. A.

JUN 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

6268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Film 02166-19-57 et

Reg. Dist. No. 100

1

1. PLACE OF DEATH a. COUNTY	Charles Maryland			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Frederick, Md.			a. STATE Pa. b. COUNTY	
c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS #7 Plymouth 75X-3	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First JAMES	Middle Edward	Last Wilson	4. DATE OF DEATH	Month 6 Day 8 Year 1957
5. SEX M	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-30	9. AGE (in years last birthday) 26 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.		11. BIRTHPLACE (State or foreign country) Edwardsville, Penna.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Wilson		14. MOTHER'S MAIDEN NAME Ruth Elmer ( )		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Capt L. E. Bell, Bolling A. F. Base	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) DUE TO Fracture base of skull 6-8-57					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Crushed Chest 6-8-57					
DUE TO (c) Auto accident 6-8-57					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 7 car collision auto					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oct 20	20f. (City or town) (County) (State) Chey.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE J. E. DeLén		DATE SIGNED 6-8-57			
EXAMINER'S NAME (Type) J. E. DeLén MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-10-57		22c. NAME OF CEMETERY OR CREMATORIALy	
22d. LOCATION (City, town, or county) Edwardsville, Pa. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS 517-11th St. S.E.		24a. REC'D BY REGISTRAR DATE JUN 11 1957	
				24b. REGISTRAR'S SIGNATURE Julia Poscyn	

WISCONSIN STATE GOVERNMENT OF HENRY-GEORGE

WISCONSIN EXAMINER CERTIFICATE OF DEATH

400000

400000

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400000

400000

400000

400000

400000

BUREAU V.

JUN 11 1957

RECEIVED